2018 OPEN ENROLLMENT ELECTION FORM – FOR NEW EMPLOYEES

INSTRUCTIONS & DEADLINE FOR ELECTIONS – Use this form to make changes to your State of Montana Benefit Plan (State Plan) coverage for the 2018 Plan Year.

- ***If the contact information you recently provided is correct, you do not want to make any benefit changes, and you do not want the Vision Hardware Plan or to enroll in a Flexible Spending Account, you do not need to return this form.***
- **If you DO want to make changes, this form must be postmarked or returned within two week of the date it is emailed to you to:** Health Care & Benefits Division (HCBD), PO Box 200130, Helena, MT 59620-0130.

PERSONAL INFORMATION

EMPLOYEE ID# _____ LAST NAME _____ FIRST NAME _____ MI ___

DATE OF BIRTH _____ AGENCY NAME _____ DATE OF HIRE _____

MAILING ADDRESS_____ CITY _____ STATE _____ ZIP _____

PHONE NUMBER _____ EMAIL _____

CURRENT BENEFITS – For information about your current benefits, contact HCBD at (800) 287-8266.

WAIVER OF COVERAGE – Check this box if you would like to waive State Plan coverage.

❑ If you check this box, you and any covered spouse/domestic partner and/or dependent child/ren will not be covered by the State Plan starting January 1, 2018. A benefit eligible employee may re-enroll at any time, but your spouse/domestic partner and/or dependent child/ren will not be able to come back to the State Plan until the next Open Enrollment Period or with a Special Enrollment Period as outlined in the Wrap Plan Document.

2018 COVERAGE ELECTION – *Only complete this section if you would like to change what you elected during your online New Employee Benefit Enrollment or if you would like to elect or re-election a Flexible Spending Account or enroll or re-enroll on the Vision Hardware Plan. Any changes made below will take effect January 1, 2018.*

- Employees on the State Plan must have Medical, Dental, and Basic Life Insurance.
- During this Open Enrollment Period, dependent children under 26 years of age and/or a spouse/domestic partner may be added. If you add a member to your plan, you will be required to provide proof of eligibility (see below for details).

Delete From Plan	Add to Plan	Name	Coverage (Circle M for Medical and/or D for Dental)	Birthdate	Relationship
			M D		
			M D		
			M D		
			M D		
			M D		
			M D		
			M D		

VERIFICATION OF ELIGIBILITY – If you are adding a spouse/domestic partner and/or dependent child/ren during Open Enrollment, you are required to submit the verification of eligibility documentation as outlined below to HCBD by **December 15, 2017**. You may submit this information via email to benefitsquestions@mt.gov with the subject line, "Open Enrollment Dependent Verification." You can also mail it to HCBD, attention: "Open Enrollment Dependent Verification", PO Box 200130, Helena, MT 59620.

- Dependent Child/ren
  - A copy of your child's/children's birth certificate(s), adoption order, pre-adoption order; or
  - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.
- Spouse
  - A copy of your marriage certificate; or
  - A copy of the front page of your tax return showing your tax filing status as "married" (you may black out any financial information); or
  - A copy of your recorded and notarized Affidavit of Common Law Marriage (available on the HCBD website at http://benefits.mt.gov/forms).
- Domestic Partner
  - A Declaration of Domestic Partner Relationship form (available on the HCBD website at http://benefits.mt.gov/forms); AND
  - Proof of a shared residence: AND
  - A copy of mutually-granted powers of attorney or health care powers of attorney; or
  - A copy of mutual designations of primary beneficiary in wills, life insurance policies or retirement plans.
- Grandchild/ren
  - A copy of a court-ordered custody agreement or legal guardianship.
- Stepchild/ren
  - Required documentation listed above for Domestic Partner or Spouse, if individual is not enrolled; AND
  - A copy of your stepchild's/stepchildren's birth certificate(s), adoption order, pre-adoption order; or
  - A copy of a court-ordered parenting plan, custody agreement or legal guardianship.

TURN OVER - ACTION REQUIRED ON BACK!

JOINT CORE ELECTION – For spouses/domestic partners who are both covered by the State Plan and have a covered child/ren. Your spouse/domestic partner must also submit a 2018 Open Enrollment Election form to elect or cancel Joint Core status.

❑ Elect Joint Core - JointCore Partner & SSN _____ ❑ Cancel Joint Core

VISION HARDWARE COVERAGE – **Enrollment is NOT automatic! You must re-elect Vision Hardware coverage each year.** You and/or your dependent(s) must be enrolled in the Medical Plan to be eligible for Vision Hardware Plan. If you check YES below **all** dependents enrolled on your Medical Plan will have Vision Hardware Coverage.

❑ Yes, I want to enroll. ❑ No, I do not want to enroll.

LIFE INSURANCE – Put an x in the box of the option you would like to elect or change. Please keep in mind if you receive a salary increase it could increase the minimum amount of Life coverage you are required to elect.

Coverage	Continue Current Coverage	Cancel Coverage	Add or Change* – New Total Amount:
Employee Supplemental Life Insurance - $5,000 increments up to 10x your annual salary.			
AD & D with Dependents - $25,000 increments up to 10x your annual salary.			
AD & D without Dependents - $25,000 increments up to 10x your annual salary.			
Dependent Life Insurance			**Not Available**
Spouse Supplemental Life Insurance - $5,000 increments up to the amount you elected for employee supplemental life.			
Long Term Disability (LTD) Insurance			

***EVIDENCE OF INSURABILITY (EOI)** – If you are making a first-time election or electing an increase of more than $10,000 to Employee Supplemental Life, making a first-time election or electing any increase to Spouse Supplemental Life, and/or a new election of Long Term Disability (LTD), you must complete an EOI application. You can access the application at www.benefits.mt.gov/Life-and-Accident or you can request the application by calling The Standard at (888) 937-4783. **Please be aware, you will not receive a reminder regarding the requirement to complete the EOI. Failure to complete EOI will result in NO life insurance enrollment or increases, beyond the $10,000 allowed for Employee Supplemental Life, without EOI.**

FLEXIBLE SPENDING ACCOUNTS (FSA) – **Enrollment is NOT automatic! You must elect or re-elect the FSA annually.** If you elect an FSA, you must also participate in the Pre-Tax Plan. When you calculate your yearly FSA contribution, keep in mind the yearly amount must be evenly divisible by 24. Your election will be adjusted to an even amount if necessary.

❑ Medical Expense FSA _____**YEARLY AMT** ($120 min/$2,599.92 yearly max)

❑ Dependent/Child Care FSA _____**YEARLY AMT** ($120 min/$4999.92 household yearly max)

READ AND SIGN

I request the election changes indicated, and authorize the associated payroll deduction.

Flexible Spending Account(s) ("FSA") - If I elect to participate in the FSA(s) for the 2018 Plan Year, I authorize the State of Montana to reduce my gross salary by the amounts indicated. I understand my election amount will remain in effect for the entire Plan Year, and only eligible expenses incurred during the 2018 Plan Year may be claimed for reimbursement. I realize this election will NOT continue for subsequent plan years. This agreement revokes all prior Employee Enrollment/Change and Salary Reduction Agreements signed by me for this 2018 Plan Year.

Adding Spouse/Domestic Partner and/or Dependents - I understand if I am adding a new spouse to my Plan, deductions for my spouse will default to the pre-tax plan. I understand if I am adding a new domestic partner and my domestic partner does not qualify as a tax dependent, deductions for his/her benefits will come out of my check after-tax. I will receive a Declaration of Tax Status form to complete, failure to return the Declaration of Tax Status form will result in my spouse/domestic partner being defaulted to a non-qualified tax status. I also understand if the tax status of a currently covered spouse/domestic partner has changed, it is my responsibility to update HCBD.

Deadline - I understand the elections I submit to HCBD will be binding at the close of the Open Enrollment Period for the 2018 Plan Year unless I or a dependent qualify for a Special Enrollment Period as described in the Wrap Plan Document.

I understand by signing below, I agree to the above Authorization Terms.

Signature:_____Date:_____

Language Assistance – General Taglines

State of Montana is required by federal law to provide the following information.

- ظة: إذا تكذ تحتدث اذرکا اللغة، فإن خدمات المعدسة اللوغةيتتوافر لك ابلمجن. التصد ربمة 855-999-1063)رقم . 1-855-999-1062 :مكهافـة الصم والوحلم
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062（TTY：1-855-999-1063)
- ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).
- ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).
- ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).
- 注意事項：日本語を話される場合、無料の言語支援をご利用いただけま.1-855-999-1062（TTY:1-855-999-1063）まで、お電話にてご連絡ください.
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.
- UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).
- ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).
- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).
- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).

State of Montana Non-Discrimination Statement: State of Montana complies with applicable Federal civil rights laws, state and local laws, rules, policies and executive orders and does not discriminate on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana does not exclude people or treat them differently because of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status. State of Montana provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). State of Montana provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact customer service at 855-999-1062. If you believe that State of Montana has failed to provide these services or discriminated in another way on the basis of race, color, sex, pregnancy, childbirth or medical conditions related to pregnancy or childbirth, political or religious affiliation or ideas, culture, creed, social origin or condition, genetic information, sexual orientation, gender identity or expression, national origin, ancestry, age, disability, military service or veteran status or marital status you can file a grievance. If you need help filing a grievance, John Pavao, State Diversity Coordinator, is available to help you. You can file a grievance in person or by mail, fax, or email: John Pavao, State Diversity Program Coordinator - Department of Administration State Human Resources Division, 125 N. Roberts, P.O. Box 200127, Helena, MT 59620, Phone: (406) 444-3984 Email: jpavao@mt.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)